Methods: Patients (>18 yrs) undergoing sleeve gastrectomy or Roux-en-Y gastric bypass during 2013 at a single centre [N=124; F=71, M=53]. A retrospective review of electronic patient records. Primary outcome was successful discharge <24 h of leaving theatre recovery. Patient, operative and peri-operative details were anaylsed to identify factors associated with failed discharge. Significance was set at $p<0.05$.
Results: 17/124 (13.7%) of patients were discharged within 24hrs. Co-morbidities (%Successful/%Failed groups), OSA (20/9, p=0.09), Asthma (0/100, p=0.09) and Diabetes (11/85, p=0.5), and additional operative events (hernia repair/cholecystectomy/adhesiolysis) (0/100, p=0.08) were not significantly associated with discharge. Successful discharge was more likely from Level 2 (27%/Total) than Level 1 care (12%/Total). Time to pharmacy conversion of medication to bariatric compatible medication was not associated, but time to prescription of discharge medication was (p=0.02).
Conclusion: Few patients are meeting current discharge targets. Efforts to improve this could include increasing staff awareness of the target, quicker preparation of discharge medication and recognition of high-risk groups/wards.

0063: IMPROVING STANDARDS OF OPERATIVE NOTE KEEPING IN PLASTIC SURGERY: A CLOSED LOOP AUDIT

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Aim: The importance of operative note recording is a vital part of communication between the multidisciplinary workforce to uphold the highest standard in patient safety and follow up. This audit compared current practice in a plastic surgery unit with standards from the Royal College of Surgeons of England, Good Surgical Practice (2008).
Methods: Data was collected prospectively from 50 consecutive operative notes between November 2013 and December 2013, and audited against the guideline . After the intervention of an educational presentation, and a poster, a subsequent re-audit was carried out between March 2014 and April 2014 of a further 50 consecutive operative notes.
Results: The results from the initial audit cycle demonstrated much room for improvement when compared with the Royal College of Surgeons guidelines. After the introduction of the intervention, there was notable improvement in 9 of the 16 criteria audited and an increase in total data recorded from 65.1% to 74.1% (p= 0.0359).
Conclusion: This audit objectively demonstrates that operative note recording standards can be significantly improved by education and complementary aide-memoirs. Despite this, there is still scope for further development and the answer may lie in implementing a universal proforma or operative note computer programme.

0094: THE TRAUMA PROFORMA: A COMPLIANCE, EFFICIENCY AND DOCUMENTATION TOOL

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Aim: Accurate and comprehensive documentation is an essential component of good surgical practice, particularly when a patient first presents for review. This audit examines the standard of surgical documentation prior to and following the implementation of a trauma proforma in a busy regional plastic surgery unit.
Methods: The admission documents for 40 patients were retrospectively reviewed and compared to the standards recommended by the GMC and royal colleges. Following implementation of the trauma proforma, a further 40 were reviewed.
Results: Key demographic data and significant elements of the patient history were omitted in pre-proforma surgical clerkings. Following implementation, the proforma increased documentation compliance (range 2.6–277.8%), particularly with regards to specialist history elements. Physical form completion time was also significantly reduced.
Conclusion: Trauma proformas serve an important role in improving the quality of documentation, in addition to acting as an aide-memoir and efficiency tool. In an era of increasing pressures, litigation and financial penalties, they are likely to have an increasing role in patient management and in the streamlining and digitalisation of services.

0143: GENERATING FINANCIAL INCOME FOLLOWING IMPROVEMENTS IN CLERICAL AMBIGUITY: AN AUDIT OF BEST PRACTICE TARIFFS WITHIN AN ORTHOPAEDIC DEPARTMENT

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Aim: Best Practice Tariffs (BPTs) is a government scheme, which aims to reduce unexplained variation in clinical quality. This is associated with a financial incentive of £250 per case. A retrospective audit was conducted assessing the orthopaedic department's compliance to the guidance associated with the BPTs.
Methods: Patient details of all upper-limb orthopaedic cases eligible for BPT were provided from the financial department over a 3-month period. Clerical notes for those eligible that did not achieve BPT were evaluated retrospectively. Results showed clerical ambiguity by clinicians in registering a patient for an operation to be the main cause for failing to achieve BPT incentives. Using existing hospital software (ICE®), an on-line electrical registration form was activated for each patient registered for surgery. Patents achieving BPT in the following 3 months were re-audited following the intervention.
Results: 64% of patients failed to achieve BPT, prior to intervention. 50% of which were due clerical errors. Following intervention only 29% of patients failed to achieve BPT with a 10% clerical error. Following intervention there has been a 45% improvement in achieving BPTs, saving £2000.
Conclusion: Small changes in clerical methods contribute greatly to departmental financial income, without any change to clinical practice.

0156: IMPROVING ACCESSIBILITY OF SURGICAL GUIDELINES AND PROTOCOLS AT THE GREAT WESTERN HOSPITAL, SWINDON

I. Robertson*, A. Smith. *Great Western Hospital, UK*

Aim: Timely access to surgical guidelines and protocols is essential to standardise best practice across the trust. Lack of organisational structure leads to time wasted locating information and ultimately potentially compromises patient safety. We aimed to consolidate all surgical guidelines into a single point of access.
Methods: We surveyed 55 junior doctors, 40% spent greater than 5 minutes to locate a protocol and 38% unable to locate some relevant documents at all. 56% felt significantly affected by the poor availability of trust documents and 100% felt improvement in access would increase ability to work effectively. All surgical guidelines and protocols currently were collated, consolidated, renamed and alphabetised according to content. Existing links were then uploaded and a single trust intranet webpage and publicised trust wide.
Results: 97% of respondents had made use of the page. All protocols were located during re-testing with 90% of those resurveyed stating it was easier to locate information. Overall, a reduction in the time to locate protocols was demonstrated: Mean time 15 s vs 60 s pre-intervention ($n = 30$). 53% of guidelines located in < 30 s and 86% < 2 min.
Conclusion: Implementation of a consolidated repository for trust guidelines and policies, saves time, money, and improves patient safety.

0206: A COMPLETE AUDIT CYCLE OF THE SURGICAL WEEKEND HANDOVER

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Aim: To determine if the surgical teams in a DGH followed the RCS guidelines 'safe handover' (2007) & to improve the efficiency of the weekend surgical oncall team.
Methods: Retrospective complete audit cycle of the surgical teams' handover sheets provided for the weekend surgical on call team. A standardised handover template and colour coded 'traffic light' system of urgency was introduced between cycles.